DaVita Rx
OUR VILLAGE PHARMACY

My Medication Card

Please complete and show this card to your doctor and pharmacist.

Name_____

Phone Number_____

Address_____

_____

Blood Type_____

Medical Condition(s)_____

_____

_____

_____

Date of Birth_____

Physician_____

Physician Phone_____

Pharmacy_____

Pharmacy Phone_____

Emergency Contact

Name_____

Home Phone_____

Work Phone_____

Cell Phone_____

Allergies

Allergic to_____

Reaction_____

Allergic to_____

Reaction_____

Medical History

Please check all that apply:

- ❍ Asthma
- ❍ Cancer
- ❍ Diabetes
- ❍ High blood pressure
- ❍ Kidney disease
- ❍ Heart disease
- ❍ Other

Over-the-Counter Medication

Please check those that you take regularly:

- ❍ Allergy relief, antihistamines
- ❍ Aspirin/acetaminophen/ibuprofen
- ❍ Cold/cough medicines
- ❍ Herbals, dietary supplements
- ❍ Antacids
- ❍ Diet pills
- ❍ Laxatives
- ❍ Sleeping pills
- ❍ Vitamins or minerals
- ❍ Other

Whenever you see a doctor, including your primary care physician, specialist or emergency room physician, review and update this medication list.

Name of Medication/Dose	Date Started	How much to take	When do you take it?	Why do you take it?

Continue medication log on back.

Medication log continued. Whenever you see a doctor, including your primary care physician, specialist or emergency room physician, review and update this medication list.

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